Siskiyou Community Health Center

School-Based Health Center General Information

What Is a School-Based Health Center?

A **School-Based Health Center (SBHC)** is a health clinic located within a school that provides medical and wellness services to students during the school day. The purpose of an SBHC is to support students' physical, mental, and emotional health so they are better able to learn and succeed in school.

SBHCs provide **accessible and developmentally appropriate care** in a familiar setting. Services are delivered by licensed healthcare professionals and may be coordinated with a student's primary care provider when appropriate.

Services May Include:

- Preventive care (health screenings, checkups, immunizations)
- Treatment of common illnesses and minor injuries
- Management of chronic conditions
- Mental and behavioral health services
- Health education and counseling
- Referrals to specialty care or community resources

Important Information for Families and Students

- Services are provided **regardless of a family's ability to pay**. Insurance may be billed when available.
- Student health information is protected under **state and federal privacy laws**, including HIPAA and FERPA, as applicable.
- SBHC staff collaborate with school personnel while maintaining clear boundaries around medical confidentiality.

The School-Based Health Center does not replace a student's regular healthcare provider but improves access to timely care during the school day.

Consent For Services

Written consent is required for School-Based Health Center (SBHC) services. Depending on the type of service and applicable law, consent may be provided by the student or by a parent or guardian. Consent is not required in a medical emergency when immediate care is needed to prevent serious harm or preserve life

Minor Consent by Service Type

Under Oregon law, minors may consent to the following services **without parent or guardian permission**:

- **General medical care**
  - **Age 15 and older** may consent
- **Mental Health Services**
  - **Age 14 and older** may consent to outpatient mental health services.
- **Substance Use Disorder Services**
  - **Age 14 and older** may consent to outpatient substance use disorder assessment and treatment.
- **Reproductive Health Services**
  - **Minors of any age** may consent.

Confidentiality Protections

When a student legally consents to care on their own:

- The services may be **confidential** if requested by the student, and health information is not shared with parents or guardians without the student's permission, except when disclosure is required or allowed by law (such as concerns about safety or abuse).
- SBHC staff encourage family involvement when appropriate and safe, while respecting students' legal rights to privacy.

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School-Based Health Center Informed Consent to Treat

Student Name	Date of Birth	Student Phone
Parent/Guardian Name	**Relationship to Student**	**Parent/Guardian Phone**

I understand that **Siskiyou Community Health Center (SCHC)** operates a School-Based Health Center (SBHC) to provide primary and preventive health care services during the school year and partners with **Options of Southern Oregon** to provide mental health and substance use disorder services. I voluntarily consent for the student named above to receive SBHC services.

Services may include: primary care; preventive care (well visits, screenings, health education); immunizations; behavioral health screening, counseling, and referrals; laboratory tests and basic procedures; and referrals to outside providers as medically appropriate.

Medical services are provided by licensed or credentialed SCHC providers, nurses, and trained staff. Behavioral health services are provided by licensed or credentialed professionals through Options of Southern Oregon.

This consent remains in effect for the duration of the student's enrollment in a Grants Pass School District 7 or Three Rivers School District school, unless revoked in writing.

Over-the-Counter (OTC) Medications
SBHC providers may administer OTC medications when medically indicated and consistent with clinic policy.

- **Middle and High school students:** OTC medications may be administered at the provider's discretion without prior parent/guardian notification or consent unless required by law.
- **Elementary students:** Parent/guardian consent is required prior to any medication administration, including OTCs, except in a medical emergency.

Confidentiality and Minor Consent

- Health information is protected by federal and state privacy laws, including HIPAA.
- Under Oregon law, students may consent to services that may be confidential.
- Limited information may be shared with appropriate school personnel when necessary to protect student health or safety and as allowed by law.

Insurance, Emergencies, and Telehealth

- SCHC may bill insurance (Oregon Health Plan or private). Students will not be denied services due to inability to pay.
- The SBHC is not an emergency facility. In emergencies, school procedures will be followed and 911 may be called.
- I consent to the student to receive services via telehealth when clinically appropriate.

☐ **Yes** **I consent to health care services offered by Siskiyou Community Health Center at the School-Based Health Center for the above-named student.**

☐ **No** **I do not give my consent to services offered.**

Student or Parent / Guardian Signature	Date

Siskiyou Community Health Center

Student Health History

Student Name: _____ DOB: _____ Today's Date: _____

Name of School: _____ ☐ Full-Time ☐ Part-Time Current Grade: _____

Does the student have any learning disabilities or special needs in school?
☐ IEP ☐ 504 Plan ☐ Learning Disabilities ☐ Special Needs in School ☐ None

Current Primary Care Provider: _____

Current Dental Provider: _____

Current Medications: _____

Allergies: _____
(medication, food, environment)

Student Medical History
Check any current or past medical conditions

☐ Abdominal Problems
☐ Acne
☐ ADD/ADHD
☐ Alcohol Use Disorder
☐ Allergies
☐ Anemia
☐ Asthma
☐ Bronchitis
☐ Chicken Pox
☐ Constipation
☐ Diabetes
☐ Ear Infections, Recurrent
☐ Eczema
☐ Fracture
☐ Head Injury/Concussion
☐ Headache, Migraine
☐ Hearing Problems
☐ Heart Murmur
☐ Menstrual Problems
☐ Pneumonia
☐ Seizures
☐ Substance Use Disorder
☐ Urinary Tract Infection
☐ Other: _____

Family Medical History
Mark any health conditions that occur in the family, including biological parents, siblings, and grandparents

☐ ADD/ADHD
☐ Alcohol Addiction
☐ Asthma
☐ Birth Defects
☐ Cancer
☐ Coronary Artery Disease
☐ Deafness
☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ Eczema
☐ Other: _____
☐ Genetic Disease
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Learning Disability
☐ Mental Illness
☐ Migraines
☐ Obesity
☐ Scoliosis
☐ Seizure Disorder
☐ Substance Use Disorder

The current recommendations are for children to have a comprehensive physical exam (check-up) performed every year. If you are interested in scheduling a **well-child exam** for your child, please indicate by checking the box below. (Please note a well-child exam is different than a Sports Physical exam.):

☐ **Yes** I would like for the above-named student to have a comprehensive physical exam (well-child check) scheduled at the school-based health center.

☐ **No** I do **not** want the above-named student to have a comprehensive physical exam (well-child check) this year at the school-based health center.

_____ _____
Student or Parent/Guardian Signature **Date**

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Student Registration for School-Based Health Center

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager.

Date: _____

Student Information

Last: _____ First: _____ MI: _____ ☐ Jr. ☐ Sr. ☐ III

Other Names Known By: _____ Phone: (___) ___ - ____

Social Security #: ___ - ___ - ____ Date of Birth: ___ / ___ / ____ Sex: ☐ M ☐ F

Responsible Party Information

Last: _____ First: _____ MI: _____ ☐ Jr. ☐ Sr. ☐ III

Relationship to Patient: _____

Social Security #: ___ - ___ - ____ Date of Birth: ___ / ___ / ____ Sex: ☐ M ☐ F

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Apt/Unit: _____
(if different from above)

City: _____ State: _____ Zip: _____

Phone: (___) ___ - ____ Secondary Phone: (___) ___ - ____

May we leave a message? ☐ Yes ☐ No ***May we leave a message?*** ☐ Yes ☐ No

Where does your child usually go for health care? _____

Insurance

☐ Private Insurance ☐ Oregon Health Plan (OHP) ☐ Self Pay

Primary Insurance *If you have insurance (including OHP) please fill out this section.*

Company: _____ **Policy/ID#:** _____

Policy Holder's Name: _____ Date of Birth: ___ / ___ / ____

Relationship to Patient: _____

Secondary Insurance *As a courtesy to our patients, we will bill most secondary insurances.*

Company: _____ **Policy/ID#:** _____

Policy Holder's Name: _____ Date of Birth: ___ / ___ / ____

Relationship to Patient: _____

Siskiyou Community Health Center

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, the following statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

Student Status
☐ Full-Time
☐ Part-Time
☐ Not Applicable

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Do you need an interpreter?
☐ Yes
☐ No

Student Primary Race
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Caucasian (White)
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other _____

Ethnicity
☐ Hispanic / Latino
☐ Non-Hispanic

Homeless
☐ Yes
☐ No

Gross Annual Household Income

$
**Annual income amount is gathered for grant funding requirements.*

Number of Members in Family

Privacy Practices – Acknowledgment

I understand that the School-Based Health Center, operated by Siskiyou Community Health Center (referred to below as "This Practice") will use and disclose health information about me which may include information both created and received by This Practice, may be in the form of written notice or electronic records or spoken words.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for insurance coverage and submit claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for qualify, cost-effective health care.

I acknowledge that this program complies with the HIPAA Privacy Security Act and a copy is available online at This Practice's website at www.siskiyouhealthcenter.com.

I have the right to revoke this authorization at any time, provided that I do so in writing and to the extent that This Practice has already used or disclosed the information based on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 12 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent/Guardian Signature: _____ **Date:** _____

The mission of Siskiyou Community Health Center is to identify and provide care for the primary health needs of our community in a professional and compassionate manner.

Siskiyou Community Health Center is a private, not-for-profit equal opportunity provider and employer.

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Slide Discount Program Enrollment

School-Based Health Center

Siskiyou Community Health Center wants to provide quality health care to our patients, regardless of their ability to pay. This Sliding Discount Program is based solely on family size and income in relation to the federal poverty level for services provided by our School-Based Health Centers (SBHCs).

Enrollment in this program is valid for the school year. To continue being considered for this program, a new Enrollment Form must be completed each school year. If eligible, your child will be able to receive medical care services at our SBHCs at a discount.

Student's Name: _____ Date of Birth: _____

Address: _____ _____ _____ _____
Street Address City State Zip Code

Phone: (_____) - _____ - _____

List household members. This includes yourself, spouse and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separate.
First Household Member should be the Responsible Party. Second Household Member should be the Student.

Name (First and Last)	Relationship to Student	Date of Birth	Gross Monthly Income

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

_____ _____
Signature (Parent/Guardian) Date

_____ _____
Print Name (Parent/Guardian) Date

For Office Use Only

Documentation Received / Determination

Family Size (#): _____ Documented Family Annual Income: $ _____

Qualifies for SBHC Slide: ❒ Yes ❒ No Effective Date: _____ Exp. Date: _____

Discount Category (circle): **A** **B** **C** **D**

_____ _____
Siskiyou Community Health Center Signature **Date**